

GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM

A. CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached claim form.

1. Please complete and answer all questions in full. Please indicate "N/A" if the question is not applicable.
2. Please submit the Original duly completed claim form and all relevant documents (see below) within **20 days** from the date of discharge from hospital or date of surgery.
3. Please submit only **original final bills** and receipts. "Duplicate" copies of bills and receipts are **NOT** acceptable.
4. Please retain copies of what you had submitted as they may be requested for audit / validation purposes. Do note that any hardcopy documents submitted will not be returned to you.

B. ON ADMISSION TO HOSPITAL

GHS

On admission, the Patient or his / her family member needs to sign the MediSave Authorization Form (applicable to Singapore citizens and Permanent Residents). A deposit may also be required by the hospital.

C. ON DISCHARGE FROM PRIVATE HOSPITAL

Please submit the following documents:

1. Part 1 and 2 of the Claim Form
2. Part 3 of the Claim Form (Medical Report from the attending Physician / Surgeon)
3. Original and Final Hospital Tax Invoice & itemised Hospital bills (including Doctor's bills and receipts)
4. Referral letter from a General Practitioner for any pre-Hospitalization / pre-surgery specialist consultation (if any)
5. A copy of the claim settlement advice from the MediSave-approved Integrated Shield Plan (if any) eg. *IncomeShield*, *PRUShield*
6. For invoices with MediSave or MediShield deduction, a copy of the payee's CPF Statement with Hospital Registration Number (HRN) is required. This statement can be downloaded from the Central Provident Fund Board website at www.cpf.gov.sg.
 - i) Click on 'View My Statement' and login to your CPF Account
 - ii) Under Section B, select 'MediSave and Healthcare Insurance Claims and Reimbursement' & input date range
7. Any other supporting documents.

D. ON DISCHARGE FROM GOVERNMENT / RESTRUCTURED HOSPITAL

Please submit the following documents:

1. Part 1 and 2 of the Claim Form.
2. Original and Final Hospital Tax Invoice & itemised Hospital bills (including Doctor's bills and receipts)
3. Inpatient Discharge Summary from the Hospital
This is provided free of charge to the patient upon discharge. If the patient is unable to submit a copy of this form, we will apply a medical report on behalf of the patient and any charges imposed by the hospital will be deducted from the benefits payable for the claim (if the claim is admitted).
4. Referral letter from a General Practitioner for any pre-Hospitalisation/ pre-Surgery Specialist consultation (if any).
5. A copy of the claim settlement advice from the MediSave-approved Integrated Shield Plan (if any) eg. *IncomeShield*, *PRUShield*
6. For invoices with MediSave or MediShield deduction, a copy of the payee's CPF Statement with Hospital Registration Number (HRN) is required. This statement can be downloaded from the Central Provident Fund Board website at www.cpf.gov.sg.
 - i) Click on 'View My Statement' and login to your CPF Account
 - ii) Under Section B, select 'MediSave and Healthcare Insurance Claims and Reimbursement' & input date range
7. Any other supporting documents.

Part 1: Details of the Employee / Patient

Name of Employer: HITACHI VANTARA	Policy No: G0009376
Name of Employee: MOORI ASHOK KUMAR REDDY	NRIC/Passport No: S7853695E
Date of Birth: 25/07/1978	Nationality: INDIAN
Marital Status: MARRIED	Plan Type: 001
Contact No: 81188449	Designation: CAPACITY MANAGER
Employee's commencement date of insurance: 26/06/2023	Gender: Male / Female

By default, approved amounts are reimbursed to the Employee. ☐ Please 'tick' this box **only** if payment (via cheque) is to be made to your **Employer**.

Please complete this section if Employee is not the Patient

Name of Patient: BOJJIREDDY SOUJANYA	NRIC/Passport No: S8477350F	Gender: Male / Female
Relationship to Employee: SPOUSE	Occupation: APP SUPPORT ENG	Date of birth: 25/08/1984

Part 2: Details of the Admission

Date of Admission: 04/12/2025	Date of discharge: 06/12/2025	Name of Hospital / Clinic: SRI LAKSHMI MULTI SPECIALITY HOSPITAL
1) If admission is due to sickness, please provide the following:		
Diagnosis: ABNORMAL UTERINE BLEEDING	Symptoms experienced: HEAVY BLEEDING WITH BLOOD CLOTS	Date when symptoms first started: 12/2023
Has the illness been treated before? YES		Date of first treatment: 03/2024
Nature of treatment / operation done: EMERGENCY HYSTEROSCOPIC GUIDED POLYPECTOMY, FRACTIONAL CURETTAGE MIRENA INSERTION DONE UNDER GENERAL ANESTHESIA		
2) If admission is due to accident, please provide the following:		
Date of accident:	Time of accident:	Place of accident:
Briefly describe what had happened and state the extent of the injury:		

3) Are you entitled to claim against Work Injury Compensation Insurance?

- ☒ No
☐ Yes - Please provide further details

4) Are you making a claim from other insurance companies?

- ☒ No
☐ Yes - Please provide Name of the Insurer, Policy Number & submit a copy of the claims settlement letter / payment voucher

Declaration and Authorization (to be signed by the Employee and Patient / Guardian)

I / we, hereby authorize, agree and consent to:

- persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons / organizations, my / our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to insurer and Fullerton Healthcare Group, its associated persons / organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below).
- the Insurer and Fullerton Healthcare Group sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
- the Insurer and Fullerton Healthcare Group, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s)
- the Insurer and Fullerton Healthcare Group collecting, using, disclosing, storing, retaining and / or processing (collectively, "Using" / "Use") the Personal Data for the Purpose, and
- waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I / we represent and warrant that the insured person(s) have granted me / us authority to so waive) to bring a claim of any nature against any of the Insurer and Fullerton Healthcare Group in respect of any above-mentioned Use and / or any Use of any Personal Data for the Purpose.

Where I / we are not the insured person, I / we represent and warrant that I / we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data, (ii) to disclose their Personal Data to the Insurer and Fullerton Healthcare Group, and (iii) for the Insurer and Fullerton Healthcare Group and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I / we hereby agree to indemnify Insurer and Fullerton Healthcare Group for all losses and damages that Insurer and Fullerton Healthcare Group may suffer in the event I / we are in breach of any representation and warranty provided by me / us herein. In this Clause, "Purpose" means any of the purposes described in the Insurer's personal data policies and Fullerton Healthcare Group Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me / us or the insured person in relation to any existing or future policy / policies / programs that I / we may hold / participate with Insurer and Fullerton Healthcare Group. This authorization shall bind my / our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my / our Application / form is accepted by Insurer and Fullerton Healthcare Group. A photocopy of this authorization shall be valid and effective as the original.

Disclaimer

Aon Care is a medical network administering insurance policies arranged by Aon Singapore Pte. Ltd ("Aon") acting as an insurance broker. Aon is not an insurer and does not guarantee the acceptance, application or availability of insurance. The content of this form has been compiled by Fullerton Healthcare Group Pte Ltd and is subject to the terms, conditions and exclusions of the regulated insurer's policy wording which may change from time to time. Refer to the relevant policy document for complete and most up to date details. Neither Aon, nor any Aon Group entity, will be held liable for the contents of this form, its existence or any representations made in its connection. For further information on Aon Care or related insurance products, please contact a representative of Aon.

[Signature of Employee]

Signature of Employee

[Signature of Patient / Guardian]

Signature of Patient / Guardian (if Patient is a dependent)

06/01/2026

Date

Part 3: Medical Report (TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON)

For admissions to Private Hospital or Hospitals outside Singapore, Claimant must arrange to have this section completed by the attending Physician / Surgeon when submitting a claim. Any fees charged for the completion of this section shall be borne by the Claimant.

1. Policy No. G0009376	2. Name of Company HITACHI VANTARA
3. Name of Patient BOJJIREDDY SOUJANYA	4. NRIC/ Passport No. S8477350F
5. Date of Birth (DD / MM / YYYY) 25/08/1984	6. Date of Admission (DD / MM / YYYY) 04/12/2025
7. Date of Discharge (DD / MM / YYYY) 06/12/2025	8. Name of Hospital SRI LAKSHMI MULTI SECIALITY HOSPITAL
9. Date of First Consultation (DD / MM / YYYY) 04/12/2025	10. Final Diagnosis Description (ICD 10) ABNORMAL UTERINE BLEEDING
11. Final Diagnosis Code (ICD 10) Abnormal uterine bleeding	12. Date of Diagnosis (DD / MM / YYYY) 04/12/2025
13. What is the cause of illness / injury? — NA —	14. What is the anatomy of this illness? — NA —
15. Details of Operation(s) / Surgical Procedure(s) performed (a) Date when it was performed (DD / MM / YYYY) 04/12/2025 (b) Type of Operation(s) / Surgical Procedure(s) (c) Operation Code(s)* Emergency Hysteroscopic Guided (d) Operation Table(s)* Polypectomy, Fractional Curettage and Mirena Insertion. *For surgeries done in Singapore and based on Tables of Surgical Procedure for MediSave Scheme 1 February 2014	16. Were the surgical procedures approached through the same incision? ☐ No ☐ Yes — NA —
17. Please indicate the treatment rendered if no surgery was done. — NA —	18. Please advise the period of medical leave given.
19. Has the patient had any prior treatment for this condition? ☒ No ☐ Yes - Please state the date of treatment, name & address of doctor who treated the patient	20. Was the patient referred by another doctor? ☒ No ☐ Yes - Please furnish the name and address of the referring doctor

Was the above condition discovered during your investigation of his / her fertility condition?

- ☒ No
☐ Yes

22. Is the condition / treatment related to:

("Circle" the relevant response)

- a. Pregnancy or childbirth (Yes / No) ☒
b. Infertility or Sub-fertility Condition (Yes / No) ☒
c. Congenital Anomaly (Yes / No) ☒
d. Genetic or Chromosomal Disorder (Yes / No) ☒
e. Mental, Nervous, Emotional or Psychiatric Disorder (Yes / No) ☒
f. Cosmetic Surgery (Yes / No) ☒
g. Correction of short-sightedness (Yes / No) ☒
h. Abortion / Miscarriage / Impotency Sterilization (Yes / No) ☒
i. If related to miscarriage, was it due to accident (Yes / No) ☒
j. Sexually Transmitted Disease / AIDS, or any other illness or Disease related to HIV (Yes / No) ☒
k. Self-inflicted injury / Drug Addiction / Alcoholism (Yes / No) ☒
l. Sleep Apnea / Obesity / Weight reduction or Improvement (Yes / No) ☒
m. Dental / gum treatment or oral mucosal (Yes / No) ☒

If "Yes" to any of the above, please provide further details below:

23. Please provide the approximate date of discovery of the illness or injury (DD / MM / YYYY)

04/12/2015

24. How long has the illness / injury existed prior to consulting you?

3 months

25. Did the patient experience any symptom(s) prior to consulting you?

- ☐ No
☒ Yes - Please indicate the nature of symptom(s) and date when symptom(s) first started

3 months

26. If an excision was performed, please indicate the size of the lesion / tumor (Please attach a copy of the Histology Report).

NA

27. Please provide name(s) of the following:

(a) Attending Physician

(b) Surgeon

Dr. K. Padma Reddy.

(c) Anaesthetist

Dr. Hari Prasad.

28. If there are no symptoms / complaints, what had prompted the patient to see you?

NA

29. Has the patient ever had a similar condition / symptom?

- ☒ No
☐ Yes
☐ Not to my knowledge

30. Doctors previously consulted by the patient for the above condition.

(a) Name of Doctor: Dr. K. Padma Reddy

(b) Date of First Consultation:

(c) Name & Address of Clinic: SRI LAKSHMI HOSPITAL

1-5-39/2, Behind Ashmi Supermarket,
New Town, Mahabub Nagar

31. Is the patient still under your care for this condition?

☐ No - Please provide the following:

1. Date when follow-up was terminated

2. Name and address of doctor (if the patient was referred to another doctor for follow-up)

☐ Yes - Please state the estimated duration that patient needs to follow-up with you

32. Was the hospitalization / procedure for investigative purposes?

☒ No

☐ Yes - Please provide further details:

33. Is this a job-related injury?

☒ No

☐ Yes - Please provide further details:

34. If this condition had existed before symptoms became apparent to the patient, please indicate (in your view) when this condition began to develop.

[Signature]

Signature of Physician / Surgeon

Dr. K. Padma Reddy

MEDICAL DIRECTOR.

Name / Designation

12/01/2016

Date

SRI LAKSHMI HOSPITAL

SRI LAKSHMI HOSPITAL

Regd. No. 161/2009

1-5-39/2, New Town,

MAHABUBNAGAR - 509 001

Name and Address of Clinic / Hospital & Stamp